Population Reports

Improving Client-Provider Interaction

James F. Phillips/The Population Council

In family planning programs good face-to-face interaction between the client and providers is key to meeting clients' needs and program goals. Programs can best improve client-provider interaction (CPI) when they move beyond just training providers and strengthen CPI continuously in multiple ways.

Good face-to-face communication between clients and providers forms a cornerstone of good-quality services, and family planning programs have worked hard to improve it. Most providers are trained professionals and caring community members who want to communicate well with clients. Why then do clients sometimes receive inadequate information or suffer poor treatment? Relying on training alone and focusing exclusively on providers, while neglecting the client's role in consultations, have held back efforts to strengthen CPI. What more can programs do?

Helping Clients Play an Active Role

Good CPI respects the client's right and ability to make informed choices. With support and encouragement, family planning clients can actively participate in their own care and make well-informed choices. Specifically, programs can:

Contents

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- **Balance the client's and provider's roles in decision-making** by teaching providers to respect clients' ability to choose for themselves and to engage clients in decision-making.
- **Explore clients' thinking about health decisions** by asking about their personal, social, and economic concerns during consultations and in monitoring and evaluation.
- **Address clients' concerns about side effects** by counseling them on what to expect before they start a method, and responding to their concerns if side effects develop.
- **Encourage clients to play an active role in consultations** by developing mass media campaigns, print materials, and client education that legitimate clients' rights and encourage them to ask questions of providers.

Strengthening Providers' Performance

Training can strengthen providers' knowledge and interpersonal skills. Programs also must address the many other factors that affect providers' ability to interact with clients. Programs can:

- **Define clear expectations for good CPI** by disseminating and reinforcing policies, guidelines, job descriptions, and protocols that promote good communication practices.
- **Give providers feedback on their performance** by focusing supervision on CPI and by encouraging coworkers, clients, and the community to help.
- **Make CPI training more effective** by refining curricula, adopting proven training methods, and supporting trainees' efforts to apply new skills on the job.
- **Provide the space, supplies, and time** that providers need to counsel clients effectively.
- **Motivate providers** by recognizing and rewarding superior performance.
- **Match workers with jobs** to ensure that providers have the knowledge, attitudes, and skills essential for good CPI.

Key Role of Evaluation

Systematic evaluation produces the objective information that managers need to improve CPI. To evaluate CPI effectively, programs must choose meaningful indicators and data sources. Involving policy-makers, managers, and service providers in the evaluation process helps ensure that recommendations respond to real needs, are feasible, and will be acted upon.

Beyond Family Planning

As family planning programs become more integrated with other health care, CPI faces new possibilities and challenges, particularly in addressing HIV/AIDS. Providers increasingly are responsible for multiple reproductive health services. Family planning clients often have other reproductive health concerns that can be addressed during clinic visits. Providers who communicate effectively with clients can learn about their interrelated sexual and reproductive health concerns and can help them become more aware of risky behavior and empower them to make healthy choices.

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Promoting Dialogue

The interaction between a health care client and provider contributes the vital human connection that leads to meeting the client's needs. Client-provider interaction (CPI) can influence clients' perceptions of the quality of care, their decisions about returning to the same provider or service site, their understanding of and adherence to medical regimes, their continuation of contraception, and even decisions about whether and when to have more children (1, 2, 48, 82, 93, 107, 115, 133). Clearly, better CPI can improve reproductive and other health programs, creating more satisfied and empowered clients and better health outcomes.

What is CPI? The term encompasses all face-to-face communication between clients and health care providers. One type of CPI, counseling, holds special importance for reproductive health care. Counseling is a dialogue in which providers use communication skills and technical knowledge to help clients make or confirm health decisions, such as choosing a contraceptive method or opting for HIV testing, and then help clients plan and prepare to carry out those decisions.

In addition to their primary providers, clients also interact with other staff at health facilities, including other midwives, nurses, and doctors as well as receptionists and guards. Because all these interactions can shape clients' experience, they, too, deserve attention.

By definition, CPI involves two-way communication between clients and providers—that is, a dialogue. Customarily, however, health care professionals and their technical concerns have dominated these interactions and the decisions that flow from them. In recent years there has been growing recognition of the importance of the client's role in consultations. For family planning an important turning point came in 1994, when the International Conference on Population and Development (ICPD) in Cairo endorsed reproductive health care focused on individuals' needs and rights (157).

Most reproductive health programs now emphasize client-centered care, which places clients' needs and concerns first and encourages greater client participation in the decision-making process (28, 150). In particular, clients' informed choice has become an avowed goal for family planning programs (159). Informed choice is a logical outcome of effective CPI, because good CPI gives clients the information they need to make sound decisions along with help considering their options.

The field of family planning has played a pioneering role in investigating the need for and nature of good CPI and exploring related issues such as informed choice and client-centered counseling. Experienced providers of family planning have learned much about how to interact effectively with clients. By drawing on this body of knowledge and applying lessons learned through experience, reproductive health programs can further improve the quality of CPI. This report synthesizes key insights on improving CPI collected by members of the Maximizing Access and Quality (MAQ) Initiative of the United States Agency for International Development and its Cooperating Agencies (see www.maqweb.org).

There are many ways for health care programs to promote dialogue between clients and providers. To support the client's role as an informed decision-maker, programs can ensure that providers understand and respond to clients' concerns and priorities. At the same time, they also can encourage clients to participate more actively in consultations (see p. 4). Programs can improve providers' performance by addressing all of the factors that influence their ability to communicate, ranging from providers' knowledge and skills to job expectations and the work environment (see p. 8). Programs also can increase the impact of training—the activity most commonly used to improve providers' communication skills—by adopting proven training practices (see p. 13). No matter what measures a program takes to improve CPI, careful evaluation can help refine their design and implementation and assess their impact (see p. 15). Lessons learned about improving CPI can strengthen family planning programs and be fruitfully applied to integrated sexual and reproductive health services such as HIV/AIDS prevention and care for victims of violence (see p. 19).

Harvey Nelson

A health worker in Ethiopia counsels a woman about her family planning choices. Counselors are most effective when they focus on the client's needs and concerns and give clients the information and assistance they need to make healthy decisions.

Supporting the Client's Role

There are two "experts" present in any health care consultation: the provider and the client (85, 142). The client's understanding of her or his personal preferences and situation is as essential to good reproductive health decisions as the provider's technical knowledge.

Only recently, however, have family planning programs learned to appreciate and support the client's role in decision-making. This requires both providers and clients to change their attitudes and behavior. To be effective, providers must understand and respect clients' perspectives and expectations, and they must tailor the information and guidance they offer to meet each client's unique needs. Likewise, clients benefit more from a consultation when they take responsibility for making decisions, actively communicate with providers, and insist on good care.

Clients' Perspectives Crucial to Family Planning Decisions

Informed choice is one of the fundamental rights of family planning clients (7, 58, 157). It takes place when a client voluntarily makes a well-considered decision based on full knowledge and understanding of the alternatives (41). But the right also carries responsibilities: clients are expected to make their own decisions regarding reproductive health after thoroughly considering the options. This is no easy task since decision-making about reproductive health is often complex and ongoing. For example, clients must decide whether and when to seek services, which family planning methods to try, and whether to continue with, change, or discontinue those methods (41). In order to facilitate thoughtful decisions by clients, providers need to understand how clients approach reproductive decisions and the challenges they face in making them.

Social context dominates decision-making. For clients, reproductive health decision-making is often an intuitive process of balancing individual needs, family responsibilities, and social expectations. Usually, the most important influences on decision-making come from outside the service delivery setting. People consider personal, social, and economic issues along with fertility and health concerns when they make contraceptive decisions (52, 147); these include relationships with partners, anticipated effects on social status, and sometimes even concerns that contraceptive side effects will limit their ability to work (22).

Before coming to a decision, people often engage in a lengthy information-gathering and decision-making process, during which they seek out contraceptive users among their friends and family and discuss their experiences (134). This process does not end when a woman adopts a method. She continues to talk with others and to monitor her own experience with the method so that she can decide whether or not to continue using it. Viewed from this perspective, clinic visits and other contacts with health care providers are brief moments in a largely social decision-making process.

Local beliefs about reproduction, health, and the meaning of physical symptoms—which may conflict with medical models—also influence people's decisions (134). In Togo, for example, menstrual changes prompted many women to discontinue hormonal methods—not because the changes were uncomfortable or inconvenient, but rather because women believed the changes were signs of sterility or serious illness (52). Dismissing such beliefs as myths and rumors only contributes to distrust between clients and providers. Rather, providers must learn to recognize their own medical assumptions and to treat clients' concerns seriously and respectfully.

Family planning programs need to consider clients in a broader context, as members of couples, extended families, informal social networks, and the larger community, and to appreciate the economic pressures, social issues, and local beliefs that shape their decisions. Providers can accomplish this by asking clients about their needs and situation and about the consequences of their decisions in terms of work, friends, and family relations.

Program managers can explore the larger context of decision-making during monitoring and evaluation activities (see p. 15). For example, extended monitoring of a mobile outreach female sterilization service in Nepal included client interviews. More than half of the clients interviewed said that they were afraid of dying from the procedure but felt the risk was worth taking to avoid another pregnancy (66).

Side effects need discussion. Contraceptive side effects are one of the most important factors in clients' decisions about family planning. Fear of side effects is pervasive. It is often grounded in real experiences (147). Misinformation and unfounded beliefs also are widespread. Anticipation of side effects may discourage people from adopting certain family planning methods, while experiencing side effects may lead women to discontinue a method (33, 53).

Training in contraceptive counseling usually covers how to discuss side effects with clients, but providers often avoid the subject because they think that negative information will scare clients away (26, 71). This strategy is self-defeating, however, since women learn about side effects from family and friends. Clients also may fear the worst if they experience side effects without warning and without understanding. Their fears may be exacerbated by local beliefs that interpret side effects as more dangerous than they are (52).

Providers can dispel many of these fears by helping women understand which side effects commonly occur, how long they usually persist, that they usually are not dangerous or signs of danger, and that they often disappear as the body adjusts. Providers must present this information accurately and in a way that is not alarming (123).

Research has found that clients counseled on side effects before starting a method are more likely to keep using it when side effects occur than clients who are not counseled about side effects (25, 91). In Mexico, for example, discontinuation rates among women using injectables

were far lower when they were thoroughly counseled ahead of time about possible side effects—17% versus 43% among those not counseled, after one year (25).

Equally important is how providers respond when returning clients complain about side effects. Rather than taking these concerns seriously, providers sometimes dismiss them as unimportant or even scold women for bringing up a subject that they have discussed before (52, 73). Providers need to understand that, even though side effects may not be harmful, they may still be inconvenient, uncomfortable, and upsetting for the client.

Reassurance about side effects, while important, is not always enough (52). Clients should be offered a choice among various courses of action—for example, waiting to see if bothersome side effects resolve over time, making behavioral changes (such as eating foods that contain iron or taking iron supplements to prevent anemia if an IUD causes heavy menstrual bleeding), taking medications (such as short-term combined oral contraceptives or a nonsteroidal anti-inflammatory for spotting when using implants), or switching methods (164).

Client and Provider Roles Need Clarity, Balance

Finding a balance between client and provider input into health decision-making is a continual challenge (135). Medical thinking has rejected paternalistic models that put decisions entirely in the hands of the provider. Yet concepts of "shared" and "informed" decision-making, which give clients a pivotal role, are new to many providers and even more foreign to clients, especially in developing countries (28).

According to the informed choice model adopted by family planning programs around the world, clients are responsible for choosing a contraceptive method and should have a deciding voice in most other reproductive health decisions as well. For their part providers play the important role of confirming or facilitating the client's decision, first by helping the client explore and assess her or his own needs, preferences, and knowledge, and then by using professional expertise, experience, and communication skills to help the client make a medically and personally appropriate decision (159).

Assuring informed decision-making can be difficult. Studies in both developed (17) and developing (71, 72) countries have found that most consultations do not fully achieve the goal of informed decision-making. One common reason for this may be lack of discussion of the client's role in decision-making. Family planning clients may not understand that, given the safe and effective contraceptive methods available, it is their right and responsibility to choose a method that fits their own personal needs and preferences. As a result, they may revert to the passive role that medical patients usually play, deferring to providers' expertise and expecting them to make the decisions (57, 71).

Providers who misunderstand the client's role in decision-making may act inappropriately as well. In the mistaken belief that decisions should be left entirely to clients, providers sometimes abdicate their role altogether (71). After providing the information that they think a family planning client needs, providers may passively wait for the client to figure out what it all means and reach a decision, without providing any further help. While an understandable reaction against older authoritarian approaches, this approach is equally flawed.

Activities designed to improve counseling and informed choice can convince providers that clients have the right and the capability to make their own decisions about contraceptive use. They also can convince providers that encouraging clients to make their own decisions will improve outcomes for the client and the program. After training in family planning counseling, for example, doctors in four Central Asian countries had more respect for the client's role in decision-making (8), while in Ghana providers were more likely to leave the final choice of contraceptive method to the client (55).

Training, along with good supervision and coaching, can make providers aware of biases—for example, in favor of a particular method or against switching methods—that threaten the client's right to make her or his own decisions. Providers also can learn how to engage clients in decision-making while retaining their own role in the process (124). Complementary activities directed to clients can teach clients how to play an active role in decision-making (see p. 7).

At this health clinic in the Philippines the receptionist and cashier treat clients with warmth and respect. Every health care worker should understand the importance of good CPI.

Provider and Client Both Play Roles in Client-Centered Counseling

The Provider's Role

Client-centered counseling requires providers, building on their personal communication skills, to achieve interactions with clients that:

1. Establish rapport:
- Assure privacy and confidentiality,
- Be positive and encouraging,
- Encourage clients to ask questions and share information,
- Listen and observe what clients say and do,
- Use a friendly tone of voice and attentive body language to convey warmth, interest, and respect.

2. Focus on the individual:
- Respond first to the client's stated need, interest, or question,
- Explore the client's lifestyle, life stage, life goals, and preferences,
- Help the client understand how these might influence family planning and other reproductive choices,
- Respond to the client's concerns, including rumors, respectfully and constructively,
- Review a returning client's experience and satisfaction with the method, including any side effects and changes in goals, lifestyle, and preferences.

3. Communicate medical information clearly:
- Focus on making or confirming the choice or decision,
- Be brief,
- Use simple, nontechnical language,
- Do not give irrelevant information or too much information at once,
- Let clients see and touch samples and models,
- Encourage questions and make time for them,
- Check that the client understands,
- Know their own biases about methods and treatments and compensate for them,
- Use memory and job aids to guide and inform the interaction.

4. Give clients their choice:
- Let clients know they have options and that the choice belongs to them,
- Offer to help clients think through the options,
- Ask clients to confirm their decisions,
- Help the returning client weigh the pros and cons of continuing versus switching methods.

5. Plan next steps:
- Help clients plan how to carry out their decisions,
- Discuss dealing with side effects, checking carefully for a client's personal concerns,
- Anticipate problems and discuss how to overcome them, including what the client can do if she makes a mistake, such as forgetting a pill,
- If possible, give clients pre-tested informational materials that they can consult at home,
- Invite clients to call or return if they have questions, doubts, concerns, or want another method,
- Schedule the next visit, if appropriate.

The Client's Role

Clients can improve the quality of their interactions with health care providers and their ability to make wise decisions if they:

1. Expect good care:
- Request privacy,
- Ask whether the provider will keep information confidential,
- Be aware of and, if necessary, draw attention to clients' rights and providers' responsibilities regarding CPI,
- Repeat their request for information or a method if the provider does not respond.

2. Elicit information:
- Request information about their options,
- Ask questions,
- Ask the provider to repeat or clarify information that they do not understand,
- Check their own understanding of information and instructions.

3. Disclose information:
- Respond fully to providers' questions,
- Volunteer information about their preferences, needs, and problems,
- Express concerns, worries, and fears,
- Openly discuss their personal situation.

4. Make thoughtful decisions:
- Accept that it is their right and responsibility to choose a method,
- Understand how their personal circumstances and needs affect the decision,
- Discuss the advantages and disadvantages of options with the provider to help choose the best one,
- Ask for instructions and any other help they may need to carry out the decision.

Sources: Kim, 2001 (107); Kim, 2003 (78); Murphy, 2000 (107); Rinehart, 1998 (124)

Counseling Models Help Guide Decision-Making

Given the challenges in balancing the client's and provider's roles in decision-making, providers need—and clients want help with—a systematic process, or series of steps, that will lead to a sound decision. At the same time, each client is an individual and so both the process and the content of counseling must respond to her or his unique situation.

Ideally, the counseling process itself should help providers individualize the consultation. To this end, most counseling approaches rely on short series of easily remembered steps that allow the provider to focus on the client's unique situation and needs. Approaches, such as the six-step GATHER model (Greet, Ask, Tell, Help, Explain, Return) (124) or the four-step REDI model (Rapport-building, Exploration, Decision-making, Implementing the decision) (42, 132), strike a balance between provider and client input into the decision-making process.

While counseling models generally focus on the provider's tasks, Young Mi Kim and colleagues, based on research in Kenya, describe the client's tasks in contraceptive decision-making in a four-step model: understand personal circumstances, consider alternatives, choose the best option, and implement the decision (71).

Counseling models can recognize and respond to fundamental differences among clients, such as a new client versus a continuing client, returning clients with or without problems, and clients with or without concerns about sexually transmitted infections (STIs) (124). Of course, providers must go beyond these broad categories in order to tailor a counseling session to the individual client. Within the framework supplied by any counseling model, providers must use interpersonal skills to elicit and address specific details of the client's situation and preferences, including the client's medical history, sexual practices, relationship with her or his partner, vulnerability to violence, need to conceal use of family planning, ability to pay for a method, even perhaps a woman's feelings about getting injections versus taking pills. (See box, p. 6.)

Clients' Participation Encouraged

When clients take the initiative during reproductive health consultations—for example, by requesting privacy, asking questions, or clarifying instructions—they improve the quality of CPI and the decision-making process. They help to keep the focus of the session where it should be: on their own needs, concerns, and priorities. They also request enough information to make a sound decision and make certain that they understand that information.

Clients may even compensate for weaknesses in the provider's counseling skills. A close analysis of transcripts in Indonesia revealed that some family planning clients took responsibility for key steps in the decision-making process often overlooked by providers, such as identifying the problem needing resolution (72).

Usually, however, clients are passive and hesitant to ask questions or state their needs. Clients, like providers, have expectations about their role in reproductive health consultations—expectations that are shaped by family, friends, and community as well as by health care providers. Many clients consider passively listening to providers and deferring to their expertise to be appropriate behavior.

What providers say (or fail to say) and how they act may either reinforce clients' negative expectations or else encourage them to speak. In Colombia and Indonesia, for example, postabortion care clients reported not asking questions because providers seemed too busy and never told them that it was acceptable to ask questions (155). Such research can shed light on local barriers to client participation (70, 76, 165).

Clients' limited communication and decision-making skills also contribute to their passivity. Most clients have little practice in formulating questions and seeking clarification from professionals or in weighing the pros and cons of various health care options. Depending on their culture, they may not even be familiar with the concept of conscious decision-making.

Gender and age differences between clients and providers, as well as educational and socioeconomic disparities, may further inhibit clients (134). Even the physical layout of a clinic and its work patterns can be a barrier to clients' participation if they deny clients uninterrupted privacy to discuss sensitive issues.

Various strategies increase clients' participation. Programs and research studies in developed and developing countries have devised a wide variety of materials and activities to encourage clients' participation in health care consultations (3, 43, 143). Most focus on two areas:

- Legitimating the client's right to speak out, so that clients will feel that it is appropriate—even expected—for them to play an active role in health care consultations; and
- Strengthening basic communication skills, so that clients feel confident in their ability to ask questions, disclose information, and check their own understanding.

Print materials have been used to accomplish both goals. For example, the International Planned Parenthood Federation (IPPF) poster on the "Rights of the Client" encourages clients to claim their rights to information, confidentiality, and privacy during consultations (58). It has been translated into more than 20 languages and displayed in thousands of clinics worldwide. Information sheets or brochures listing sample questions are another approach. They can encourage clients to formulate their own questions for providers and remember to ask them during the consultation (79).

Mass media campaigns can portray clients playing an active role in interactions, giving clients a model for their own behavior. Because the mass media reach a wide audience, these portrayals also may change community norms about clients' behavior. For example, communication campaigns in Egypt and Nepal developed television spots and radio soap operas depicting client-centered counseling (39, 153). While their main objective was to raise clients' expectations of providers' behavior, the broadcasts also modeled positive client behavior, such as requesting information. Observations of counseling sessions in Nepal found that clients became more active participants after the radio soap opera aired, regardless of

Young Mi Kim for IPPF/JCCP

In Indonesia a coach uses a "Smart Patient" brochure to help a client prepare questions for the provider. Clients can improve the quality of CPI by playing a more active role in sharing information and asking questions.

whether their providers had received CPI training and so might be expected to encourage such behavior (152).

Coaching clients individually on their role in CPI has been tested in Indonesia. Educators from the State Ministry of Population/National Family Planning Coordinating Board (BKKBN) spent about 20 minutes with each family planning client. They explained that clients had both the right and the responsibility to speak out. They helped clients to formulate and write down questions and concerns and to practice raising them with the provider. A comparison of experimental and control groups found that coaching persuaded clients that they had the right to speak, enhanced their participation, and improved providers' information giving, but it had only a marginally significant impact on the contraceptive continuation rate at an eight-month follow-up (79).

Group education, whether in the waiting room or in the community, can reach far larger audiences than individual coaching. In a pilot test of this approach in Indonesia, specially trained community workers led group meetings in villages, factories, mosques, and clinics. They discussed clients' rights and responsibilities, instructed women to complete a picture checklist of common questions before seeing a family planning provider, and encouraged them to ask questions and express concerns during consultations. According to household interviews, women were more likely to prepare questions ahead of time for providers and asked more questions during consultations if they lived in communities where these group meetings were held (69).

Reproductive health programs using a broader women's empowerment approach also have stimulated client participation, as two projects conducted by feminist organizations in Peru have demonstrated. Workshops for women conducted by Consorcio Mujer (139) and the ReproSalud project (29) discussed reproductive rights and gender issues as well as health care. This approach raised women's self-esteem, appreciation of their rights, and reproductive health knowledge, which, in turn, led women to openly discuss problems with providers, ask them questions, and request services. Community and provider groups sponsored by Consorcio Mujer also negotiated initiatives to improve CPI, including procedures to reward or discipline clinic staff members based on how well they interact with clients (139).

Many family planning programs try to influence clients' behavior indirectly, via training and other activities designed for providers. Training in client-centered counseling, for example, instructs providers to give clients more opportunities to talk, to prompt clients to ask questions and express concerns, and to facilitate clients' decision-making (159). In Indonesia this kind of interpersonal communication and counseling training for providers increased the average number of questions that family planning clients asked, even without activities directly encouraging clients to participate (77).

Improving Providers' Performance

Although there is growing appreciation for the client's role in reproductive health consultations, most efforts to improve CPI continue to focus on the provider. There are obvious ways to affect the provider's side of the partnership—through training, supervision, policy, management, and funding. Managers today understand that many factors contribute to providers' performance on the job. They realize that the organizational environment in which providers work is as important as the providers themselves.

Performance Improvement (PI) offers a useful framework for understanding these factors. PI is one of many models developed to analyze and improve performance in business and health care, and reproductive health programs in developing countries are successfully applying it to their operations (87). Experience in developing countries suggests that six factors most influence reproductive health care providers' behavior on the job (24, 59, 102):

- Job expectations,
- Performance feedback,
- Knowledge and skills,
- Work environment,
- Incentives and motivation, and
- Capacity.

To assure good CPI, program planners and managers must consider all six of these factors and define objectives, allocate resources, and design policies, standards, procedures, and management systems accordingly.

Because each situation is unique, there is no universal solution when poor CPI poses a problem. Before deciding how to improve providers' performance, program

staff should systematically analyze the root causes of any gap between current and desired performance. In the Performance Improvement approach, for example, staff members collect information from records, site visits, interviews, and facilitated discussions in order to define specific problems and identify their causes (87). Knowing the root causes helps managers and staff members decide on effective, feasible, and sustainable ways to resolve problems—and avoids wasting resources on activities that will not help.

Table 1 lists some of the interventions most commonly undertaken to improve the quality of CPI in health care. While some have more obvious links with CPI than others, all help ensure that the organization and its staff value, promote, and practice good CPI (see Table 1).

Make Good CPI a Job Expectation

Good interpersonal communication becomes the norm at a health care facility when all of the staff—from the medical director to the providers to the receptionists—clearly understand their contribution to client-centered services. When staff members do not understand what is expected of them or they receive conflicting messages, the problem may be that official policies, standards, and guidelines do not cover CPI or are outdated.

Policy-makers and program managers need to identify desired communication behaviors in national policies and guidelines, develop standards to define their quality, and help providers and their supervisors operationalize these standards. While local facilities managers can promote good communication practices, it is difficult for them to sustain job expectations without reinforcement from higher levels.

It is equally important to make sure that providers are aware of CPI policies and guidelines and know how to apply them as part of day-to-day service delivery. Simply distributing written copies of guidelines is not enough.

Managers can involve providers in drafting job descriptions and protocols (step-by-step instructions for procedures) that reflect the guidelines. They can regularly remind providers what the policies and guidelines require of them. They can make sure that all training and supervisory activities follow and reinforce the guidelines. And they can develop job aids, such as checklists or cue cards, to remind providers what to do (151).

In Kenya, for example, the Ministry of Health, with the collaboration of JHPIEGO and Family Health International

Table 1

Performance Factors and Examples of Activities to Improve CPI

Performance Factor	*Possible Activities to Improve CPI*
Job expectations	• Revise or draft new national policies and standards • Revise or draft new regional, district, and local standards • Revise or draft detailed position descriptions with the participation of providers • Have providers and supervisors plan how new skills will be used on the job after training • Promote social norms at local facilities that reinforce job expectations • Tell clients what to expect, using print materials, mass media, and group education
Performance feedback	• Focus supervision on CPI • Appraise overall performance at least annually • Offer timely on-the-job feedback • Develop a self-assessment system for providers • Set up a system for providers to offer supportive feedback to one another • Create client and community feedback systems and dialogue • Teach clients how to provide feedback to the provider during interactions
Knowledge and skills	• Incorporate training on good communication and counseling practices into preservice education • Focus in-service training on job responsibilities and observed weaknesses in counseling skills and knowledge • Focus training in technical content on information most important for clients • Update guidelines to reflect current technical information • Teach providers how to obtain and adapt the latest technical information • Produce and train providers to use job aids and reference materials
Work environment	• Revise work processes to allow adequate time for CPI • Create reliable logistics systems for contraceptives and other supplies • Set aside private space for consultations, and honor confidentiality • Develop community outreach programs that include in-home counseling as well as group education
Incentives and motivation	• Offer fair salaries • Eliminate gender inequity in the workplace • Give promotions, extra training, and other rewards based on performance • Recognize “Employees of the Month” • Develop accreditation programs with rewards • Encourage recognition by coworkers • Informally show appreciation for a job well done
Capacity	• Assign jobs based on skills, knowledge, and expertise • Create a system to keep track of staff members’ assignments and training

(FHI), disseminated updated reproductive health and family planning guidelines. In addition to holding training workshops, they created a laminated job aid summarizing key points from the guidelines, gave trainees an orientation package to help them update their coworkers, and made supportive supervision visits to reinforce the training. This cascade training approach reached more than 6,000 providers at the central, district, and local levels in 1999 and 2000. It significantly improved the knowledge, practices, and attitudes of providers who attended the workshops and, to a lesser extent, of their coworkers (145).

Certification and accreditation programs, which monitor facilities' compliance with established standards, provide another way to communicate and reinforce job expectations (50). Accreditation systems for reproductive health services in developing countries, such as Brazil's PROQUALI Project (64) and West Africa's Santé Familiale et Prévention du SIDA (SFPS) Gold Circle Initiative (65), typically include CPI standards along with other criteria for quality of care. Communication campaigns designed to promote accredited clinics also help to set norms for providers' behavior among both providers and clients.

Informal social norms at health care delivery sites may either undercut or reinforce job expectations set by policies and guidelines. In Kenya, for example, counseling skills deteriorated when some providers laughed at newly-trained coworkers for using job aids or for spending a few extra minutes with clients. Even supervisors sometimes criticized providers' efforts to improve their counseling skills (131).

Whole-site training—in which a facility's staff decides together on what kinds of instruction are needed—promotes a team approach to service delivery and mutual understanding of staff roles. It can help ensure that all workers at a facility share the same high standards for CPI (19). Encouraging supervisors and staff members to understand the aims of CPI training and acively support coworkers who attend such training also can build positive norms at service delivery facilities (see p. 15).

This evaluation card from Peru asks clients about the quality of care they received. Clients' opinions powerfully motivate providers to offer better care.

Feedback Keeps Performance on Track

With job expectations in mind, each health care worker should receive clear, constructive, and regular feedback on her or his performance, including praise as well as suggestions for improvement. Feedback can—and should—come from peers and clients as well as supervisors. While feedback on CPI is mostly directed to providers, it is helpful to give feedback to other staff members who interact with clients—for example, praising a receptionist who provides extra information about the clinic to an anxious new client.

Supervision is the most common, and potentially the strongest, channel for formal feedback to providers. Supervisors, however, often lack the knowledge and the tools to provide effective feedback on counseling and other communication skills. In Zimbabwe, for example, a study of 16 supervisors found that they were strong at giving feedback on technical matters, such as recordkeeping and clinical procedures, but not at giving feedback on the quality of CPI (80). Supervisors felt uncomfortable giving this kind of feedback because their checklist contained few items related to CPI and they lacked strong interpersonal communication skills themselves.

To generate effective feedback on providers' communication and counseling performance, reproductive health programs may need to strengthen the existing supervision system or add a new component to it. Effective CPI supervision requires supervisors to observe consultations and other interactions with clients, provide feedback to individual staff members and groups, identify weaknesses, and develop plans for improvement (see box, p. 11). Additional training and practice in interpersonal communication and an observation guide for CPI helped supervisors in Haiti (16) and the Philippines (32) carry out these tasks.

Supervision of CPI also benefits from a supportive, or facilitative approach, in which supervisors work with providers and other staff members to resolve problems and improve performance (13, 40, 101). In Mexico the Instituto Mexicano del Seguro Social/Solidaridad (IMSS/S), with assistance from the Quality Assurance Project (QAP) and the Johns Hopkins University Center for Communication Programs, trained supervisors to assess doctors' CPI performance with an observation checklist, give them constructive feedback, and help them select specific communication skills to work on. After four months and two supervision visits, doctors working with trained supervisors were more likely than their peers to foster rapport and client participation and to offer clients information and counseling (68).

Feedback should not be left solely to external supervisors who may visit facilities infrequently. On-site managers and coworkers, who are present all the time, can be good sources of feedback as long as job expectations are clearly established, known, and accepted by all (23, 38, 101). Feedback from coworkers can be especially valuable because they understand the challenges that their colleagues face and can accurately assess their performance (49). Feedback from fellow providers proved influential at the Ghana Registered Midwives' Association, which made peer review a regular part of monthly business meetings (111).

Self-assessment, in which providers monitor their own skills and performance, provides another source of feedback (15, 101). By assessing their own performance dur-

ing consultations against a list of clear standards, providers in Indonesia were able to identify their own strengths and weaknesses and decide which communication skills to improve (77). Self-assessment proved even more powerful in Mexico (68) and Haiti (16), where providers listened to audiotapes of their own consultations.

Clients also are a source of direct and powerful feedback on provider performance. When clients are taught to expect and request good CPI, providers respond accordingly (152). To capture client feedback systematically and improve the way clients were treated at health centers in the Dominican Republic, the Dominican Social Security Institute (IDSS), with technical assistance from PRIME, created a system of client comment cards and suggestion boxes. By reviewing and discussing clients' suggestions at the weekly staff meeting, the director of each health center made providers aware of client concerns—such as impoliteness and lack of punctuality—and the need for change (98).

■

Range of Knowledge and Skills Needed

Providers cannot practice good CPI unless they have both communication skills and technical knowledge. They need to understand the counseling process, help clients with decision-making and problem-solving, and understand social and other issues that affect clients and their needs. At the same time, they need current, accurate knowledge—or ready access to information—on contraceptive methods and related reproductive health topics such as HIV/AIDS and other STIs. Training, support from supervisors and coworkers, and well-designed job aids are crucial to helping providers develop and apply these interpersonal and technical skills.

Preservice education offers the best opportunity to develop strong CPI skills and build technical knowledge (136). All health workers attend some sort of preservice education, while the availability of later in-service training is unpredictable. Preservice education, which may involve a year or more of study, also provides time and opportunity for students to develop important attitudes and skills and for the curriculum to address complex issues. Experience has shown that preservice education shapes the way providers practice throughout their careers. Later efforts to change knowledge and behavior often encounter a great deal of resistance.

While preservice education can lay a sound foundation, both new and experienced providers also require periodic in-service training and continuing education to update information and refresh their skills over the course of their careers (114). Learning takes place less formally as well, as coworkers and supervisors help providers apply, perfect, and retain the skills they acquire in training. To encourage this kind of informal learning, supervisors should stress the importance of good care and foster an atmosphere of mutual accountability, so that providers believe that it is right to acknowledge mistakes and ask how to improve. Because of the central importance of training, the next chapter discusses best training practices in detail (see p. 13).

Well-designed job aids can help providers integrate their knowledge and skills into interactions with clients (67, 83, 93). Flipcharts, for example, serve as memory aids for providers during consultations and keep interactions focused, while simultaneously giving clients essential information. In Honduras providers reported that a pocket guide helped them remember and apply key interpersonal communication skills, elicit more information from clients, and provide better care (36).

Job aids also can improve providers' attitudes by helping them handle complex situations. In Kenya, for example, a laminated checklist of questions designed to rule out pregnancy made providers feel more favorable towards providing contraception to nonmenstruating women (146).

Reference materials at the work site, such as handbooks or information sheets, enable providers to look up information that they cannot remember or to review key concepts taught in training. Every service delivery site should have a copy of the national guidelines and protocols that operationalize essential technical and medical information on family planning. Reference materials also may cover interpersonal communication and counseling skills. In Mexico, for example, young doctors regularly consult-

How Supervisors Can Improve and Maintain Good CPI

1. Strengthen their own knowledge and skills:

- Understand the need for effective CPI, and support improvement,
- Model good communication skills with staff and clients.

2. Contribute to effective training:

- Work with providers to identify their training needs, and participate in performance needs assessments,
- Discuss training needs and curriculum content with the trainer,
- Meet with providers before training and debrief them afterwards to help them make the most of the experience.

3. Encourage and support providers' good performance:

- Become comfortable observing how clients and providers interact,
- Use checklists and other tools to evaluate providers' performance,
- Give providers constructive feedback on their interaction with clients,
- Help providers address barriers to good CPI,
- Emphasize confidentiality, and ensure that the physical setting allows for private consultations,
- Reward good CPI with praise,
- Ensure the availability of communication aids, contraceptive samples, and informational materials.

4. Develop other sources of reinforcement:

- Develop peer groups, inside the facility and among facilities, that support good CPI,
- Create rewards that motivate providers to excel at CPI.

ed a series of color-coded information sheets on key communication skills after supervisors began assessing how well they interacted with clients during consultations (68).

Work Environment Supports CPI

Physical aspects of the work environment can support—or undermine—providers' efforts to improve CPI. For example, a quiet, private space for consultations permits privacy, confidentiality, and uninterrupted attention from the provider (63), while adequate and reliable contraceptive supplies allow clients to carry out informed choices rather than settle for whatever method is available (137).

Policies and procedures that govern work flow and staffing patterns also shape the work environment. They influence CPI by determining how much time providers can spend with each client and how much time clients spend waiting before they see a provider.

It may be difficult or impossible in the short term to change basic elements of the work environment, such as clinic spaces, client load, and staffing patterns. Yet creative solutions are possible even without substantial additional resources (63). During a reproductive health initiative led by the government of South Africa and the Women's Health Project, staff at one clinic responded to time-flow and workload studies by dividing the workload more evenly, reducing the recordkeeping burden on providers, creating all-purpose consultation rooms, and having each client see a single nurse for all services. These changes enabled nurses to dramatically increase the amount of time they spent on direct patient care and to counsel each client on a fuller range of sexual and reproductive health issues (44). Hundreds of facilities in developing countries have achieved similar benefits by applying the COPE (Client-Oriented Provider-Efficient) self-assessment and problem-solving approach to identify problems and develop solutions (18, 37, 38, 99).

Rewards Offer Motivation

Incentives and rewards can motivate providers to practice good interpersonal communication and counseling skills even when conditions are less than optimal—for example, when staff shortages increase providers' workloads or when contraceptives are in short supply Supervisors may not be able to offer providers better pay or financial bonuses for good performance, but they can identify other ways to motivate them, such as:

- Formal or informal recognition of superior performance, such as an "Employee of the Month" program or praising providers in the presence of coworkers (151);
- Constructive feedback—for example, during follow-up visits from supervisors and trainers (156); and
- Certification and accreditation programs that include CPI indicators among the criteria for quality of care (50).

Managers should make certain that any incentives or rewards offered do, in fact, support good quality of care rather than numerical targets. For example, rewards for promoting a specific contraceptive method, regardless of clients' individual needs and circumstances, discourage good CPI and violate a client's right to informed choice (63).

Match Capacity with Jobs

Capacity refers to how well workers' talents, knowledge, and skills fit the jobs they are expected to do. In the case of family planning counseling, managers should select (or train) providers so they have the specialized technical

Family planning workers in Cameroon celebrate their hospital's "Gold Circle" award for meeting quality standards. Certification and accreditation programs reinforce job expectations about CPI and motivate providers.

knowledge, sympathetic attitudes, and other counseling skills essential to helping clients make informed choices. Then they should assign the providers to sites that allow them to use those abilities—that is, to facilities that are equipped to offer family planning services and are committed to good CPI. In reality, however, managers in developing countries often have limited ability to assign, retain, retrain, or replace personnel as needed (87).

Computer-based systems can help managers track workers' training needs and match them with jobs. For example, the Malawi Nurses and Midwives Council is developing a computerized database to track the registration of nurses and midwives, their deployment by location and type of facility, and their training and continuing education needs. This database eventually will become the foundation for a recertification process for nurses that will require continuing education (86).

Select Approaches to Solve Problems

As the Performance Improvement model emphasizes, improving providers' knowledge and skills with training is not sufficient to guarantee good CPI. Reproductive health programs also have to address many aspects of the organizational environment, including policies and guidelines, supervision and other feedback systems, the work setting, and the provision of rewards and recognition. By reviewing all of these factors to see whether they support or frustrate providers' efforts to communicate with clients, managers can focus their efforts to improve CPI on specific identified weaknesses.

Best Practices in Training

Over the past decade there has been a shift in both the content and format of CPI training in family planning and reproductive health. Until the mid-1990s training emphasized the acquisition of knowledge, particularly information about contraception. Since then, curricula have increasingly focused on interpersonal communication skills and the relationship between client and provider. At the same time, there has been a systematic effort to identify and adopt more effective training practices.

Advances in measuring CPI performance also have contributed to stronger training. Behavioral checklists such as the Quick Investigation of Quality (QIQ) (104) and the MAQ checklist (138), while not created for training purposes, can help planners develop measurable performance objectives for trainees and assess whether they have been met (see table, p. 17, and box, p. 18).

Reproductive health programs can improve the quality of CPI by adopting these new approaches to curricula, training practices, and performance assessment and by applying them to both preservice education and in-service training. Some skills are relatively easy to address with training, including assuring method choice, greeting clients, and paraphrasing clients' questions (148). Some significant challenges for CPI training remain, however, such as addressing the social distance between clients and providers and overcoming providers' reluctance to discuss side effects with clients.

Curricula Cover Process, Tailoring

No matter what their subject, effective training curricula share certain characteristics. Their learning objectives are SMART—that is, Specific, Measurable, Attainable, Realistic, and Time-bound. Varied training techniques and activities can be employed, but all encourage participation, build on trainees' existing knowledge, and support the achievement of specified learning objectives. The overall curriculum and sections within it follow a logical, announced order. Clear, detailed instructions for the trainer are included, and the instructions contain all of the guidance, information, and examples necessary for the trainer to organize the session, create an effective learning environment, conduct the training, and evaluate it. Materials are laid out and presented in a way that makes them easy to use for both trainer and participants (161).

As for content, CPI curricula recognize that a family planning consultation is a continuum with several important moments: establishing and maintaining rapport, exchanging information, sharing decision-making, and planning next steps. Practical curricula teach providers structured approaches to counseling that help them organize the process and remember the important moments in the interaction (132). Curricula may cover communication habits designed to keep consultations on track and use time efficiently—such as always asking a client seeking a family planning method, "Do you have a method in mind?"

At the same time, providers must react and respond to each client's unique needs, so CPI curricula also teach providers how to tailor the interaction to the client's individual situation, health status, and information needs. By focusing on the client's needs, the provider is more likely to give the client the method that she or he prefers rather than one that the provider chooses. When clients obtain the method they want, they are more satisfied and use the method longer (54, 118).

Tailoring information to the client's circumstances and priorities has the added benefit of using limited counseling time more effectively (1). When family planning programs in Jamaica, Honduras, and Brazil decided to add a sexuality focus, providers concentrated on the clients' needs and discussed information relevant to those needs rather than delivering a set lecture on methods (12). Thus they could make time for better counseling without lengthening consultations.

In addition to fostering individualized and interactive counseling, strong CPI curricula provide strategies to prevent information overload, advise how to deal with misinformation and rumors, and encourage use of take-home reminders for clients.

Most current CPI training materials focus on:

- The counseling process, including the decision-making process embedded within it,
- Listening skills,
- Understanding the client's needs and priorities,
- Respecting a client's choice of family planning method,

Chekh Fall for PHJ/CCP

In Senegal two health care providers attending a CPI training workshop practice counseling one another. Proven training methods, such as modeling and supervised practice, increase the effectiveness of CPI training.

- Addressing the client's risk for STIs,
- Using simple language,
- Technical knowledge of contraception, family planning, and reproductive health,
- Counseling about side effects, and
- Meeting the needs of special groups, such as men, adolescents, and post-abortion clients.

While these topics are important, training materials often do not give enough attention to other significant issues, including social distance, gender-related issues such as violence against women, and issues of sexuality (148). Despite the considerable coverage given to contraceptives, curricula also are weak when it comes to assisting with method switching, addressing the advantages of family planning methods, and suggesting how different methods might affect a client's daily life. More also needs to be done to encourage and help clients to communicate with their sexual partners about family planning and preventing STIs (see p. 19).

The provider needs to understand the client as a person. Training curricula should address communication skills that enable providers to elicit and meet clients' needs. Providers can learn how to help clients identify their reproductive goals, how to respond to clients' concerns and misconceptions, and how to explore sensitive areas such as sexual practices and violence—and to do so in a manner that makes the client feel as comfortable as possible. Teaching these skills may pose a challenge if providers are used to dealing with a medical problem rather than a person and do not feel confident discussing a client's personal situation. As trainers help providers master these new skills, they also must help providers eliminate unhelpful behavior, such as interrupting and showing disrespect (74, 130).

Training also can help providers understand the special challenges facing certain groups of clients—due to their age, gender, or life circumstances—and to respond appropriately, without passing judgment. For example, providers who work with adolescents need to know about sexuality, puberty, and other concerns of youth, and they must be aware of youth-friendly referral resources. They also must respect young clients' autonomy (11). Male clients and couples also present challenges to providers who are used to dealing only with women (125).

Training can help providers clarify their values and attitudes. Training curricula increasingly focus on the counseling relationship and how the provider's belief system influences the interaction. Providers need to understand and take into account their own attitudes regarding:

- Their role as medical experts,
- Their perception of and respect for the client, and
- Family planning and other services that they offer.

By establishing a trusting relationship with providers, trainers can promote the open exploration of their beliefs.

Training can help providers understand how their values affect their counseling practices—for example, by making them reluctant to offer contraceptives to unmarried adolescents or to explore domestic violence. This kind of training also can encourage providers to learn strategies to counteract their own biases, to persevere during difficult or awkward interactions with clients, and to see their own nervousness as a challenge rather than a limitation (89).

Exploring personal values and feelings also helps providers develop their ability to connect with clients and quickly draw out clients' needs and concerns. This requires both self-awareness and empathy—that is, providers must understand the sources of their own feelings at the same time that they experience and appreciate clients' feelings (47).

Training can increase providers' self-efficacy—that is, their confidence in their own abilities (9, 89)—by helping them master essential skills and knowledge (16). Self-efficacy is an important bridge between knowing what to do and taking action (10, 89). In other words, if providers feel confident that they have the counseling skills needed to help clients, they are more likely to use their skills.

Adopt Proven Training Methods

Proven training methods increase the effectiveness of any type of training, including training on CPI.

- ***Microskills training*** breaks counseling down into specific interpersonal communication skills, such as body position, asking questions, reflection of feeling, summarizing, and feedback (35, 61). After trainees master individual skills, they integrate them during practice.
- ***Modeling*** uses live or videotaped demonstrations of good counseling to help trainees develop essential

skills, appreciate different counseling styles, and develop a sense of self-efficacy (81, 89).

- ***Supervised practice,*** beginning with role plays and followed by sessions with real clients, gives trainees the opportunity to practice in situations as close to reality as possible and to receive feedback. Positive feedback from trainers can strengthen providers' self-efficacy (89), and constructive feedback from peers can help build new group norms regarding good CPI and attitudes towards clients.
- ***Experiential learning*** starts with a group activity or exercise that enables participants to experience a situation relevant to their work. Then they reflect together on their reactions, identify lessons learned, and apply their insights by planning specific changes in their behavior (108).

Training outside the classroom may reach more providers than classroom training. Family planning and reproductive health projects have successfully tested a variety of alternative CPI training approaches (31, 84, 97). In Nepal, for example, distance education via radio proved as effective or slightly more effective than conventional workshops at improving providers' communication skills (153). In Ghana self-directed learning (127) with print materials helped midwives improve their CPI performance with adolescents (109). In Zimbabwe interactive computer instruction (83) allowed students at a school of midwifery to proceed at their own pace and increased their knowledge of technical and communication topics (21).

Many Contribute to Transfer of Learning

Knowledge does not always translate into behavior (94, 110). Ensuring that health care workers apply newly learned knowledge and skills on the job requires the active cooperation of the trainee, the trainer, the on-site supervisor, and coworkers (122). The process ideally begins before training, when providers and supervisors create an action plan for applying newly learned skills, coworkers discuss the need for and potential benefits of training, and trainers design activities, training materials, and job aids that connect formal learning to providers' daily tasks.

Some of the most important activities take place after a course ends (122). If training is not supported and reinforced when providers return to the job—a common situation—there is little sustained change in providers' behavior. In Indonesia, for example, analysis of audiotaped family planning consultations found that the quality of providers' communication increased immediately after training, but without reinforcement the newly acquired skills eroded over the next four months (77).

Supervisors play a key role (36). Ideally, they observe or participate in the training themselves so that they can act as coaches and role models when providers return to work. Trainers also can help providers overcome difficulties in applying new skills on the job if they continue to advise trainees after the course ends (122). Even coworkers can contribute to the transfer of learning by encouraging providers to demonstrate and apply their new skills.

Studies have tested several reinforcement strategies following CPI training workshops, including supervision, self-assessment, peer review, and refresher courses (16, 32, 68, 77). In Turkey specially trained three-member teams used an observation checklist to rate providers' communication and clinical skills during a series of five follow-up clinic visits. They offered feedback, coaching, demonstrations, and role-playing to refresh providers' skills (114). In a social marketing program in Pakistan, trainers made annual visits to providers, during which they conducted a semi-structured monitoring interview, reminded providers of good practice, and invited them to refresher training (116). In Indonesia providers conducted weekly self-assessment exercises, rating their own interpersonal communication skills during a selected consultation; some also attended peer review meetings (77). Regardless of the approach, regular reinforcement improved providers' on-the-job performance of CPI skills.

Transfer of learning may pose an even greater challenge after preservice education than after in-service training because there may be little correspondence between the academic environment and the worksite. Nevertheless, many of the same strategies apply. Preservice curricula, training activities, and training materials should be based on current policies and service delivery guidelines that promote CPI, and they should address the realities of the jobs that students will fill upon graduation (136). Well-supervised internships and practica during preservice education can give students the opportunity to put new knowledge, skills, and attitudes into action in real-life settings, with immediate feedback from instructors. After graduation, new health care workers may need extra coaching and reinforcement from supervisors until they become proficient at their jobs.

Evaluating the Quality of CPI

Monitoring and evaluation are essential for any effort to create and maintain good communication between health care providers and clients. Without monitoring and evaluation, it is difficult to know how well providers are performing, how satisfied clients are with services, what problems exist, and whether attempted improvements are effective. The evaluation process also spurs the design of innovative approaches to CPI improvement and tests their usefulness.

Depending on its purpose, a CPI evaluation may range from an informal review of practices at a single clinic, conducted by and for frontline staff, to a rigorous assessment of an entire program conducted by outside experts for the benefit of policy-makers and donor organizations. CPI can be the subject of a stand-alone evaluation or part of a broader evaluation.

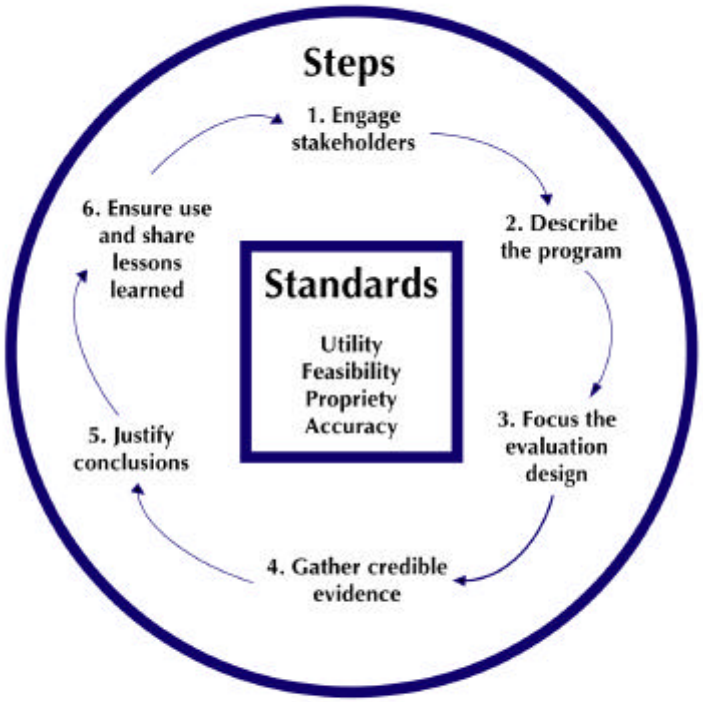
No matter what approach is used, CPI evaluations are most helpful when they take a broad view and proceed systematically. To capture the many and varied factors that influence the quality and effectiveness of CPI, evaluations should look at more than how the client and provider interact. They also should examine the technical

accuracy of information communicated and whether the facility and larger organizational systems support good CPI. Following a systematic process such as the six-step framework shown in Figure 1 ensures that the findings of CPI evaluations will be credible, relevant, and useful (27).

Liza Nackerman for IPHU/JCDP

Staff members in Ecuador study data about program performance. Involving managers, providers, and a range of stakeholders in a CPI evaluation makes it more likely that all will value the results.

Figure 1. Framework for Program Evaluation in Public Health



Source: Centers for Disease Control and Prevention, 1998 (27)

Population Reports

By following this six-step process, reproductive health programs can design and implement a CPI evaluation strategy that will meet four key standards: it will fulfill users' information needs (utility), be realistic (feasibility), follow ethical principles (propriety), and produce correct information (accuracy).

Step 1. Engage Stakeholders

Many people have an interest in how well a family planning program functions, including providers, clients, community members, managers, and policy-makers. Engaging them in the design and implementation of a CPI evaluation helps ensure that the evaluation will reflect varied opinions and address important concerns (5, 149). It also makes it more likely that stakeholders will value the results and act on recommendations (20, 162).

Step 2. Describe Program Goals

Researchers must understand what a program is trying to achieve before they can measure its effectiveness. This requires a thorough program description that, in the case of CPI, first sets out objectives such as informed choice and confidentiality. Then it explains how various program elements (ranging from contraceptive supply and facility layouts to counseling guidelines and supervision systems) are meant to help achieve these goals.

Step 3. Focus the Evaluation Design

The purpose of an evaluation determines its design and methodology, including what counts as evidence, how data are gathered and by whom, and what claims can be made about the results. Generally, evaluations fall into one of two categories, depending on their intentions (119, 128, 129):

- ***Formative evaluations*** identify ways to improve program operations—for example, by assessing the strengths and weaknesses of CPI supervision practices.
- ***Summative evaluations*** measure the outcomes or impact of a program—for example, by assessing whether an accreditation system met its objective of improving the quality of CPI.

Formative evaluations tend to use fairly simple, often qualitative research methods and deeply involve stakeholders in design, implementation, and analysis (119, 129). For example, a formative evaluation of the quality of care at the local level in Tanzania employed a highly participatory approach. Fifty local supervisors helped design a quality measuring tool for staff teams, who used it to observe operations in their own facilities and to reach consensus on whether family planning services met pre-established standards. This approach motivated staff members to examine the quality of services honestly and to address service delivery problems (20).

In contrast, summative evaluations require relatively sophisticated research designs and rigorous, quantitative methods because they drive policy and program decisions at the national or international levels (119, 128, 129). For example, a summative evaluation of the impact of radio serials on CPI in rural Nepal required a well-trained team of data collectors, analysts, and statisticians, substantial resources, and complex logistics. The Radio Communication Project conducted baseline and

post-intervention surveys of a nationally representative sample of married women; pre- and post-tests of health workers who participated in distance education via radio; three waves of observations and client exit interviews at selected clinics; and an analysis of client flow data from sentinel health posts (153).

Step 4. Gather Credible Evidence

The credibility of evaluation findings depends on the kinds of data collected, their quality and quantity, and the methods used to collect the data (27). Two issues are crucial: translating CPI concepts into measurable indicators and choosing appropriate sources of data (92).

Indicators must be specific and measurable. Assessing the quality of CPI requires translating general objectives, such as establishing rapport or giving clients their choice, into specific, measurable indicators of an individual's or a program's performance. Credible indicators also reflect reliable and objective information and are sensitive to changes in performance.

Creating measurable indicators that accurately assess interpersonal communication and counseling has proved difficult (140). Many indicators require subjective judgment—for example, deciding when a provider has sufficiently explored a family planning client's needs and preferences. Others, such as listening attentively, may be hard to rate because they are nonverbal or vary across cultures. Even seemingly clear-cut indicators, such as the accuracy of information given, can be surprisingly difficult to assess in the context of actual conversation.

Table 2

Illustrative CPI Indicators from the Quick Investigation of Quality (QIQ)

QIQ Indicator	Data Collection Method: Client Exit Interview	Observation	Facility Audit
PROVIDER:			
Assures client of confidentiality		✓	
Asks client about reproductive intentions (e.g., "More children? When?")	✓	✓	
Discusses with client which method she would prefer	✓	✓	
Treats client with respect/courtesy	✓	✓	
Tailors key information to the particular needs of the specific client	✓		
Gives accurate information on the method chosen (how to use, side effects, complications)	✓	✓	
Gives instructions on when to return	✓	✓	
Recognizes/identifies medical eligibility criteria consistent with guidelines		✓	
STAFF (other than provider):			
Treats client with dignity and respect	✓		
CLIENT:			
Participates actively in discussion and selection of method	✓	✓	
Receives her method of choice	✓	✓	
Believes the provider will keep her information confidential	✓		
FACILITY:			
Has all approved methods available; no stock outs			✓
Has mechanisms to make programmatic changes based on client feedback			✓
Has received a supervisory visit in past _____ months			✓
Has up-to-date clinical guidelines			✓

Source: MEASURE Evaluation, 1999 (103)

Population Reports

Many organizations have developed extensive lists of CPI indicators as part of training evaluations (42) or facility assessments (7). Table 2 presents CPI indicators from the Quick Investigation of Quality (QIQ), a practical, low-cost, and well-tested tool for measuring the quality of care in family planning services (104, 154).

Multiple data sources strengthen conclusions. Observations of consultations, interviews with clients and providers, and facility audits are common sources of data for evaluating interpersonal communication and counseling. Frequently, CPI evaluations draw on multiple sources of data so that they can offset each other's weaknesses and so that the consistency of the results can be tested (119).

Approaches to observation have varying advantages and drawbacks. Three approaches have been used for observing client-provider interactions: direct observation, interaction analysis, and simulated clients. Direct observation calls for trained observers—often field workers or supervisors—to watch the consultation and assess the quality of the interaction using a structured observation guide (7, 68). The presence of an observer, however, is the method's greatest drawback. When clients know they are being observed, they may be less likely to speak, while providers may try harder than usual. Proper selection and training of observers are key to the reliability of the data; otherwise, different observers may interpret and report providers' actions differently (14).

Interaction analysis of audiotapes or videotapes may avoid the potential bias caused by an observer's presence, but it costs more (73). After recording and sometimes transcribing the consultation, researchers use a coding guide to classify and quantify everything said by both client and provider (36). Self-assessment tools that help providers assess their own performance, based either on memory or on a tape recording, are a variation on interaction analysis (68, 77).

The simulated, or "mystery," client approach trains people from the community to recognize what constitutes good care and then sends them to seek health services

Evaluating CPI Training Programs

A health worker in Nepal takes a test after completing a training course. Thorough evaluations of CPI training compare providers' knowledge before and after training and assess changes in their CPI practices on the job.

A complete evaluation of CPI training assesses both the quality of the training event and its impact on providers' behavior on the job. This requires evaluation before, during, and after training (42, 161):

- Before the design of a training event, a needs assessment can determine who should be trained, what they need to learn, and whether the health care system is ready and able to make the changes necessary for providers to apply new CPI skills.
- At both the beginning and the end of the training event, trainers should assess participants' CPI knowledge, attitudes, and skills through questionnaires, interviews, and observations. The baseline data can help direct the training, while before-and-after comparisons can determine whether training objectives are met.
- During the training event, trainers should monitor participants' progress so they can make adjustments in the course (34).
- After the training event, the actual implementation process should be compared with the original plans to see what succeeded and why, and to identify which materials and activities were most helpful.
- After participants return to work, observations can assess whether training has changed their everyday CPI practices. Further evaluation can determine if the changes had an impact on client satisfaction, return visits, or contraceptive continuation.
- Several months to one year after training, further rounds of observation can determine whether improved CPI practices persisted.

without revealing to the provider that they are participating in a study. The simulated client reports back to researchers on her experience with the provider and the facility. Carefully defining the profile of the simulated client and limiting reports to specific provider behaviors and facility characteristics increases the objectivity and reliability of reports (96, 120). Of course, this approach cannot assess clients' behavior.

Interviews elicit clients' and providers' opinions. Interviewing clients immediately after their consultations can reveal what took place and whether clients left satisfied. Clients may not accurately remember what happened during the counseling session, however, or they may confuse it with group talks and other clinic events (14). More importantly, a combination of low expectations, courtesy bias (telling interviewers what they want to hear), and fear of criticizing people in authority encourages clients to report complete satisfaction with services and to avoid criticizing the clinic and its staff—thus skewing results in a positive direction (14, 36, 104). Evaluators can reduce this bias by conducting interviews in private (56), away from the facility, using personnel who do not work at the clinic involved (104).

Structured or semistructured interviews with providers can assess their knowledge of family planning, interpersonal communication, and counseling. Interviews may be especially useful for probing providers' attitudes toward contraceptive use among groups such as adolescents, single women, men, sex workers, women without children, or women with many children. Providers' actual practices, however, do not always match their knowledge or their professed attitudes (116).

Facility audits assess the setting for CPI. Observers can make site visits to gauge a facility's readiness to provide quality services, including CPI. For example, observers can assess whether the layout of the building permits privacy for consultations, whether CPI guidelines and job aids are in place, and whether logistical systems assure a steady supply of contraceptives (104).

Step 5. Justify Conclusions

To interpret findings, assess their program implications, and make practical recommendations, researchers need to consult with stakeholders (5, 112). To help stakeholders understand evaluation results, researchers should put the data into context—for example, by comparing results with past performance, national standards, or findings elsewhere. They also should propose alternative explanations for the findings and discuss the likelihood of each (27). In return, providers and managers can contribute their knowledge of the practical realities to the discussion, including an understanding of political priorities and resource constraints.

During an evaluation of client education on essential communication skills in Indonesia, for example, researchers sought feedback from clients, providers, client educators, and program managers (78). Managers pointed out that the instructional method tested—individual client coaching—was not feasible on a large scale, while clients and educators suggested that self-learning, group talks, and the mass media could teach clients the same skills. Researchers drafted recommendations accordingly.

Step 6. Ensure Use and Share Lessons Learned

To ensure that an evaluation has a real impact on service delivery, researchers should create a strategic plan to disseminate the findings and convince decision-makers to take appropriate action. Many factors affect whether decision-makers pay attention to evaluation results, including the packaging and dissemination of findings, decision-makers' opinions about the relevance of research findings and the credibility and authority of the researchers, organizational norms, and the difficulty of the decision to be made (88, 113, 149).

Program managers and policy-makers are more likely to act on recommendations if they were involved in earlier stages of the evaluation process—for example, in formulating the research questions—and if they receive clear and cogent synopses and interpretations of the findings. A communication plan should identify distinct intended audiences—for example, Ministry of Health officials, district managers, supervisors, family planning providers, and community members—and then tailor messages and communication channels to each one (4, 5, 112).

Curriculum for Integrated Reproductive Health Counseling

A new curriculum developed by EngenderHealth has adapted counseling frameworks from family planning to address a range of integrated sexual and reproductive health services. Applying evidence-based best practices in CPI, *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum* promotes effective communication and counseling in all areas of reproductive health. The training package includes materials for a six-day workshop to teach providers the knowledge, attitudes, and skills they need to assess and address a client's overall sexual and reproductive health needs, regardless of the health care setting or the service requested by the client. Also included are agendas for shorter workshops and for other frontline staff, administrators, and supervisors. For copies of the curriculum, send an e-mail message to info@engenderhealth.org or write to EngenderHealth Material Resources, 440 Ninth Avenue, New York, NY 10001, USA.

Moving Beyond Family Planning

In keeping with the recommendations of the ICPD Programme of Action, family planning services increasingly are being integrated with other sexual and reproductive health services. In addition to family planning, integrated sexual and reproductive health services may address HIV/AIDS and other STIs, infections and cancers of the reproductive system, infertility, gynecological and maternity care, postabortion care, gender-based violence, and education on sexuality and parenting (51, 157). The need to look beyond contraception when working with family planning clients has created new challenges and opportunities for CPI.

Focus STI Counseling on the Individual

Providers must do a better job of addressing risk assessment, prevention, and treatment of HIV/AIDS and other STIs. Since family planning service delivery may be one of the few contacts that women have with the health care system, providers have a unique opportunity and responsibility to help clients make appropriate choices to protect against both unintended pregnancy and STI/HIV infection (144).

Providers may be reluctant to raise potentially embarrassing topics with clients, however, especially if the clients are married and therefore assumed—sometimes incorrectly—to be at low risk of infection. This reluctance may help explain why in the mid 1990s only about one-quarter of 3,000 clients received information about HIV/AIDS and/or STIs during maternal and child health and family planning consultations in five African countries (Botswana, Ghana, Kenya, Zambia, and Zimbabwe) (105).

Some common strategies to incorporate STI/HIV issues into family planning counseling are problematic. Adding STIs and HIV/AIDS to the routine background information given to all clients may not be feasible because of the time pressures on providers; it also raises the danger of overloading clients with more information than they can absorb (107). Giving STI/HIV information only to clients who fit a high-risk "profile"—for example, sex workers or women whose husbands travel—is no better. Profiles do not reliably identify individuals at risk of infection, and they unfairly stigmatize some clients (141).

Instead, information about STI/HIV risk assessment, prevention, and treatment should be a standard part of clinic health talks, community education, and mass media campaigns. During consultations, providers then can focus on assuring that each and every client understands what behaviors are risky and how to protect themselves from possible infection. In family planning consultations, this means helping clients assess their STI risks so they can choose an appropriate method or combination of methods (30, 158).

Family Planning Providers Can Aid Victims of Violence

Worldwide, it is estimated, at least one woman in every three has been beaten, coerced into sex, or otherwise abused (51). Violence against women and girls can be physical, sexual, psychological, or economic, but coerced sex and abuse within marriage are among its most common manifestations.

Reproductive health care providers have a unique opportunity and special responsibility to help victims of gender-based violence because:

- Such abuse can have a major impact on women's reproductive health and sexual well-being;
- Violence and powerlessness can limit women's ability to make informed and voluntary decisions about their sexual and reproductive health; and
- Reproductive health providers may be these women's only connection with the health care system and community support services (51).

Health care systems need to make a commitment to identify and address the needs of abused women and children. Many providers are unaware of the extent of violence against women. Some may even contribute to the problem by trivializing abuse or treating it as normal behavior, blaming the victims, violating their confidentiality, and placing their safety at risk (117). Victims have a range of needs, and supportive CPI can open the door to addressing those needs.

Training, guidelines, and job aids can help providers recognize their own values and biases, develop empathy, and improve their communication skills on sensitive issues such as sexual abuse (45, 60). In Venezuela, for example, the percentage of new clients who disclosed a history of violence rose from 7% to 38% after the Asociación Civil de Planifación Familiar (PLAFAM) held special awareness and skills training workshops for providers, introduced a counseling protocol and screening form, and developed informational materials for clients (46).

Good CPI Benefits Sexual and Reproductive Health

The integration of family planning and other sexual and reproductive health services creates the opportunity to adapt and apply CPI principles and lessons learned in family planning to other health services. Potential benefits are twofold: increased recognition and protection of clients' rights and improved quality of care.

A counselor in Paraguay discusses domestic violence with women attending a village health fair. As family planning is integrated with other reproductive health services, providers must be ready to counsel clients on a broad range of health concerns, including violence and HIV/STIs.

The right of the client to make and carry out reproductive decisions has driven much of the work on CPI in family planning. The ICPD Programme of Action recognizes the right of couples and individuals to make such decisions freely, without discrimination, coercion, or violence (157).

Attention to client's rights is even more important in the broader arena of sexual and reproductive health. For example, a breach of confidentiality carries greater risks of stigma and violence when it concerns postabortion care or HIV/AIDS than when it concerns contraception (126). Also, concerns for the health of others, such as the partner of a client with an STI, may create pressures against the client's right to make her or his own decisions. If these rights are not protected, clients will avoid seeking health care, which ultimately defeats the greater public health cause and, in effect, denies the client access to services.

Good CPI can improve the quality of care in other sexual and reproductive health services as it has in family planning. Interpersonal communication and counseling by providers can help address a wide range of clients' needs—for example, by:

- Providing emotional support during delivery, postabortion care, or HIV testing,
- Establishing a trusting relationship that allows a woman to disclose domestic abuse or an adolescent to explain why she needs family planning services,
- Building a client's self-confidence so she feels able to ask her partner to use condoms,
- Ensuring that a client understands why STI treatments must be continued even after symptoms have disappeared, and
- Clearly explaining that an STI client will be reinfected unless her or his partner also is treated for the infection.

These positive outcomes of good CPI benefit individual clients and their partners, help to prevent and treat disease, and establish health care facilities as places where people are respected and their needs are met.

CPI Principles Apply to Integrated Services

Providers may question whether clients' rights and other CPI principles developed in family planning apply to other reproductive health services. Family planning clients are, on the whole, healthy individuals making elective decisions. In contrast, clients who come to health care providers for other reproductive health services may need immediate treatment, requiring providers to make medical decisions.

It may help to think of the relationship between clients and providers in sexual and reproductive health care as a dynamic interaction that depends upon:

- The urgency of the health care need,
- The potential health impact of the decision,
- Whether the decision to be made is primarily medical or primarily based on the client's personal preferences and situation,

- The availability of multiple treatment options or method alternatives with the same or comparable outcomes,
- Broader health implications for other individuals or the community in general, and
- The likelihood that providers' or clients' values and attitudes will adversely influence communication and decision-making (6).

The timing and exact nature of CPI varies, based on these factors. Even—or especially—in life-and-death situations, however, a client's right to make her or his own decisions and have access to relevant information remains important.

Programs should prepare reproductive health care providers to weigh all of these factors when interacting with clients with varying needs and in various states of wellness or illness (42). As family planning is merged into broader reproductive health services, providers are becoming responsible for offering more services. Even when providers are assigned solely to family planning services, their clients are likely to have other reproductive health needs and concerns that can best be identified and often addressed during family planning visits.

Providers should be prepared to elicit, assess, and address clients' interrelated sexual and reproductive health concerns, whatever service a client needs or requests, by referral, if necessary. CPI training for integrated services emphasizes seeing the client as a whole person and making a comprehensive assessment of each client's needs, while relying on the same repertoire of essential counseling skills used to deliver family planning services (42). When communication is truly "client-centered" and providers feel comfortable discussing issues other than the clinical aspects of family planning, clients can guide the interaction and counseling so that their broader needs are met.

Tools for Improving CPI: CD-ROM Available

The Johns Hopkins University Center for Communication Programs has produced a CD-ROM, *Client-Provider Communication: Successful Approaches and Tools*, that highlights evidence-based best practices and recent innovations for improving client-provider interaction. It covers four areas: provider performance, client behaviors and community norms, management of service delivery, and research and evaluation. Program descriptions and evaluation findings demonstrate how the approaches can be implemented. The CD-ROM includes a variety of sample tools, including counseling guides, client education materials, and supervision and assessment forms, along with advice on how to adapt them for different settings. For copies of the CPI CD-ROM, send an e-mail message to orders@jhuccp.org, fill out the order form at http://www.jhuccp.org/cgi-bin/orders/orderform.cgi, or write to: Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health, 111 Market Place, Suite 310, Baltimore, MD 21202, USA.

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